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"Examining the Conceptual and Empirical Bases of the Tax Exemption of Not-for-Profit
Hospitals"

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EXAMINING THE CONCEPTUAL AND EMPIRICAL BASES
OF
THE TAX-EXEMPTION OF NONPROFIT HOSPITALS

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THE GROWING NUMBER OF CHALLENGES TO NONPROFIT HOSPITALS

The public's perception that nonprofit hospitals are becoming more "business-like" while seeming to provide less health care for the poor and the medically indigent challenges nonprofit hospitals to demonstrate the existence, vitality, and uniqueness of their nonprofit health care missions. However, the public is not the only source of a growing concern about the way nonprofit hospitals are currently choosing to provide health care services. For-profit competitors, legislators, and the courts have also joined the ranks of the critics.

For example, for-profit competitors question the seemingly unjustified competitive advantage nonprofit hospitals receive through exemptions from local, state, and federal taxes. Legislators, moreover, eye the potential influx of additional revenue that would come to federal and local governments if tax-exemption policies were to be repealed. For example, in terms of the federal corporate income tax -- currently a rate of 34% -- Simpson and Lee (1987) estimated that for California in 1985, the annual federal tax revenues foregone as a result of tax-exemption totaled roughly \$198 million, and that the annual foregone state income tax revenue was approximately \$41 million. Noting the

potential sources of error in their estimates, Simpson and Lee concluded:

When combined, the California and federal income tax exemption results in lost tax revenues from nonprofit community hospital operations of \$239 million. Thus, the combined income and property tax revenue loss from the nonprofit community hospital tax exemption is \$300 million in California, with \$102 million of that revenue loss borne by California government at the state and local level. (Simpson and Lee, 1987, p.7)

In addition to the loss of revenue from the corporate income tax exemption, the federal and state governments lose revenue through the tax-deductible donations made to organizations by individuals who deduct their contributions under Section 170.c.2 of the Internal Revenue Code (IRC). Moreover, nonprofit hospitals are exempt from federal unemployment taxes, the communications excise tax, and are eligible to use tax-exempt revenue bonds to finance capital projects (Clark, 1989).

While nonprofit hospitals realize substantial savings through exemptions from federal and state corporate income taxes, it is the exemption from state and local property taxes that provides the largest benefit to nonprofit hospitals. According to Simpson and Lee, the "annual revenue loss to local governments from the property tax-exemption for nonprofit community hospitals [in California] is in excess of \$61 million" (Simpson and Lee, 1987, p.6)

How serious are the challenges to nonprofit hospitals to demonstrate why they deserve preferential treatment from the federal government? Recent activity in the courts, in Congress,

in state legislatures, and in the private sector testifies that the challenges to the nonprofit mission are serious and multifaceted.

The Seriousness of Court Challenges

In terms of activity in the courts, growing numbers of nonprofit hospitals have become involved in litigation over their tax-exempt status. Most prominent among recent court cases is that of Utah County v. Intermountain Health Care, Inc. (1985), where the Utah State Supreme Court denied the property tax exemption to two nonprofit hospitals and established a six-part test which the local tax board could use to determine whether nonprofit hospitals made a contribution to the community. Evidence of service to the community was a key component in this court's decision to withdraw the exemption from these nonprofit hospitals. Specifically,

[t]he court examined the distinctions between not-for-profit and for-profit hospitals, the extent to which the two hospitals involved were supported by donations and gifts, the 'profit' derived from operation, the charges levied on patients, the level of charity care provided, and several other factors before concluding that the hospitals did not qualify as charitable institutions. (Hyman and McCarthy, 1988, pp. 32-32)

In evaluating each hospital's operations with respect to these standards, the Utah State Supreme Court noted the importance of the nonprofit hospital's making a "gift" to the community, whether through charges lower than the prevailing

market rate, or through an imbalance of services rendered relative to the value received for them. The Court found that

[t]he evidence was that both hospitals charge rates for their services comparable to rates being charged by other similar entities, and no showing was made that the donations identified resulted in charges to patients below the prevailing market rate..., and it is they who bear the burden of showing their eligibility and exemption.... The record also shows that neither of the hospitals in this case demonstrated any substantial imbalance between the value of the services it provides and the payments it receives apart from any gifts, donations, or endowments. The record shows that the vast majority of the services provided by these two hospitals are paid for by government programs, private insurance companies, or the individuals receiving care....It is precisely because such a vast system of third-party payers has developed to meet the expense of modern hospital care that the historical distinction between for-profit and nonprofit hospitals has eroded. (709 P. 2nd 256, 1985, pp. 11,13)

In summary, the Utah Supreme Court concluded that it believed that

...the defendants in this case confuse the element of gift to the community which an entity must demonstrate in order to qualify as charity...with the concept of community benefit, which any of countless private enterprises might provide....[M]eeting a public need by a provision of services cannot be the sole distinguishing characteristic that leads to an automatic property tax-exemption....We cannot find...the essential element of gift to the community, either through the nonreciprocal provision of services or through the alleviation of a government burden. (709 P. 2nd 265, 1985, pp. 17-19)

While no other courts have adopted the Intermountain rationale (Clark, 1989), there have been several other challenges to the tax-exempt status of nonprofit hospitals. For example, in Burlington, VT, the city government has appealed a Superior Court decision rejecting a \$2.83 million property tax assessment. In

California, a nonprofit hospital with a "profit" margin of over 10% paid \$305,000 in county property taxes before the state Attorney General upheld the exemption based on "peculiar statutory language" (Clark, 1989).

In Pittsburgh, the Presbyterian-University Hospital has voluntarily agreed to pay the city \$11.25 million in service fees over the next ten years. In addition, two other Pittsburgh hospitals are currently fighting similar efforts to place them on the tax rolls.

In Nashville, seven hospitals have temporarily won a reprieve from paying \$5.4 million in property taxes, and another hospital has won an appeal on a \$500,000 property tax assessment. In nearby Chattanooga, the Tennessee Appellate Court has rejected a tax assessor's attempt to tax a hospital on the grounds that it did indeed improve the conditions in the community (Clark, 1989).

In Dallas, the Texas attorney general has threatened to dissolve several nonprofit hospital corporations on the grounds that they are not acting like charitable institutions in accordance with their state-granted charters (Hyman and McCarthy, 1988). And in Missouri, a nonprofit hospital has had to establish that it operated at a loss for two years and spent approximately 5% of its operating expenses on indigent care before the state Appellate Court rejected an attempt to tax it on the grounds that it had denied some services to indigent persons (Clark, 1989).

The Nature of Congressional Concern

The courts have not been the only governmental body to challenge nonprofit hospitals to give evidence of how they are fulfilling their mission and why they should be exempt from taxation. Congress has also begun to scrutinize the activities of the nonprofit sector. For example, members of Congress such as Ways and Means Chairperson Daniel Rostenkowski (D-IL) and Oversight Subcommittee head J.J. Pickle (D-TX) have sought testimony on the unrelated business income tax (UBIT). Later, they advised the IRS to improve its data collection efforts on tax-exempt organizations, especially on UBIT activities.

The IRS mandate was prefaced by Congressman Pete Stark's (D-CA) earlier testimony before Congressman Pickle's House Subcommittee on Oversight, Committee on Ways and Means. At the UBIT hearings, Congressman Stark leveled an attack against the current policy of tax-exemption for nonprofits. Citing Simpson and Lee's 1985 estimates of the levels of charitable care being provided in California relative to tax subsidies, Congressman Stark claimed that "not-for-profits in California received a tax-exemption worth \$300 million but only provided \$82 million in charity care."

Anticipating inquiries from Congress about the effects of the policy of tax-exemption, the Government Accounting Office (GAO) has authorized a three-part study of tax-exempt nonprofit organizations. Their study, which is to be completed in 1989, includes an examination of the history and background of the

charitable organization tax subsidy, an analysis of the tax expenditures resulting from the policy, and a survey of hospitals to gather information about non-revenue producing charitable services (Abernathy, 1988).

State legislative committees have also been examining the privileged status of tax-exempt nonprofit organizations. For example, in Pennsylvania, a special legislative committee has been formed to study competition between for-profit and nonprofit enterprises. Other tax related legislation has been or is being considered in Minnesota, Oklahoma, Florida, Missouri, Virginia, and West Virginia (Hyman and McCarthy, 1988).

Clearly, nonprofit hospitals need to make efforts to demonstrate precisely the nature and extent of the contributions they make to society if they intend maintain their tax-exempt status. But what types of behaviors and outcomes must they demonstrate? In part, the answer to this question is found in Section 501.c.3 of the Internal Revenue Code (IRC). This section, while rather ambiguous, reflects both the historical and theoretical development of nonprofit organizations, and the many rationales that have been generated subsequently for granting tax-exemptions to nonprofit hospitals.

SOME BACKGROUND ON NONPROFIT HOSPITALS: A TRADITION OF STEWARDSHIP, SERVICE, TRUST, AND LEGITIMACY

In general, nonprofit organizations have enjoyed a long and distinguished history of being identified with public

stewardship, of serving the diverse needs of a variety of people, and of enjoying a high level of legitimacy and trust (Hall, 1987). Much the same could be said of nonprofit hospitals with their long tradition of making health care available to the poor (Starr, 1982).

Most of the earliest hospitals were established by voluntary community or religious groups (Anderson, 1985). Church groups were particularly integral to the development of hospital-centered health care insofar as they offered a place where care could be provided for the poor. The wealthy, more often than not, received care in their homes, and it was not until later when the wealthy began to seek the services of surgeons that the hospital was considered an appropriate site for health care (Anderson, 1985; Starr, 1982).

However, it was not long before these hospitals, grounded in a tradition of charity care for the poor, began to respond to the effects of a rapidly industrializing capitalist society that transformed hospitals from almshouse infirmaries to public and voluntary hospitals sponsored by wealthy philanthropists and/or religious organizations. In a relatively short time, hospitals went "from treating the poor for the sake of charity to treating the rich for the sake of revenue and only belatedly gave thought to the people in between" (Starr, 1982, p. 159). It was not until the government took a more active role in the health care of its citizens and voluntary and private insurance were offered through

the work-place that nonprofit hospitals were able once again to provide for any significant number of poor people.

In recent years, nonprofit hospitals have been caught in a financial squeeze, and many nonprofit hospitals have cut back substantially on charity services and on services to the local community. Since these charity cutbacks, many nonprofit hospitals have begun to lose their credibility and legitimacy with many as nonprofit charitable institutions.

LINKING THE HISTORICAL AND THEORETICAL DEVELOPMENT OF NONPROFIT ORGANIZATIONS

Nonprofit organizations, and nonprofit hospitals among them, have been characterized by a tradition of public stewardship, by diversified service to a range of people, and by a widely held, though currently eroding, public perception of legitimacy and trust. Given this history, what theories have been offered that reflect this tradition and explain the subsequent growth of the nonprofit sector?

In general, researchers have identified three types of arguments to explain why organizations take the nonprofit form:

- 1) nonprofits exist to maximize goals other than profit (usually either altruistic, religious, or ideological goals);
- 2) nonprofits are viewed as a response to governmental failures;
- 3) and nonprofits are a response to market failures, especially contract failure resulting from information asymmetries, transaction costs, or agency problems.

The Nonprofit Form: A Way To Maximize Goals Other Than Profit

Prominent among the reasons for some organizations taking the nonprofit form is that nonprofits exist to maximize something other than profit. This set of theories is based on the assumption that it is the objective function of nonprofits that differs from for-profits rather than the inputs of the organization.

What might nonprofits be maximizing that makes them differ from for-profit organizations? Several goals, some ideological, some pecuniary, and some altruistic, have been suggested.

The more ideological include the following: the ideological goals or motivations of the founders of the organization (Rose-Ackerman, 1986a,b; Young, 1983; James and Rose-Ackerman, 1986) and, most especially, the founder's or manager's religious goals

or vision of a just society (James and Rose-Ackerman, 1986; Rose-Ackerman, 1986a,b).

Toward the more pecuniary, the following have been suggested: the manager's own goals, expense preferences, income, power, or prestige (James and Rose Ackerman, 1986; Niskanen, 1971, cited in Young, 1983 and in James and Rose-Ackerman, 1986; Williamson, 1964, cited in James and Rose-Ackerman, 1986, and in Gassler, 1986); the power and prestige of the organization or charity (Tullock 1966a, cited in Young, 1983, and in James and Rose-Ackerman, 1986); or the organization's total budget (Niskanen, 1971, cited in James and Rose-Ackerman, 1986).

More altruistic and communitarian orientations can be explained by the behavior of managers who want to maximize quality service (Hansmann, 1980; Rose-Ackerman, 1983, cited in James and Rose-Ackerman, 1986); or of those who want to engage in works that serve the public interest (Weisbrod, 1979, cited in Young, 1983); or who want to "buy into" an organization by contributing to it or by engaging in communal behavior (Rose-Ackerman, 1986b); or who have been socialized into unselfish behavior (Margolis, 1982).

The actions of nonprofit managers may reflect perceptions of self-interest that do not fall easily into any of the above categories. For example, a manager, because he or she cannot benefit too directly or too obviously from the activities of the organization, may try to cross-subsidize one organizational activity with another. Typically, this is accomplished by down-

grading the quality of one activity to subsidize the other one that he or she, for whatever reason, prefers (James, 1983; Hansmann, 1980).

In addition, the assumption of altruism on the part of nonprofit institutions has been challenged. For example, Pauly and Redisch (1973), argue that nonprofit hospitals arise as "physicians' cooperatives" where physicians work together to maximize their own incomes.

Given the wide variety of goals other than profit that nonprofit organizations might choose to maximize, what, in particular, might nonprofit hospitals be attempting to maximize? At the time of their founding, the goal of the nonprofit hospital did not seem to be the maximization of profit as much as the maximization of access to health care. Whether for religious or ideological reasons, nonprofit hospitals expanded the health care opportunities to the poor, the disenfranchised, and/or those who were discriminated against on the basis of race, religion, or color. Clearly, the desire of the founders of nonprofit hospitals was to enhance the social welfare of the populace. Altruism, whether for religious or ideological reasons, seemed to play more of a role in motivating this type of behavior than did the possibility of making a profit. An important element of the current debate over the tax-exempt status is whether this altruism has remained central to the mission of nonprofit institutions.

The Nonprofit Form: A Response to Governmental Failures

In contrast to theories which hold that nonprofits arise in order to maximize goals other than profit, Weisbrod (1977) argues that nonprofits arise due to governmental failures. Governments, he argues, while still having the ability to compel behavior in order to overcome free-ridership problems, often fail to produce the goods and services society wants because they, like private individuals, lack information about consumer demands. Moreover, because a government, like an individual, can operate in its own self-interest rather than following the "collective will" of the people in its allocation of goods and services, it may not choose to produce the goods and services in which some segment of society has expressed an interest. Thus, "depending on whether the publicly provided good is primarily a collective or individual type good," nonprofit organizations will supplement the public production of public goods (Weisbrod, 1977, p. 69).

As "quasi-governmental organizations," nonprofits provide goods similar to those provided by the government (Lee and Weisbrod, 1977). For example, in their empirical study of nonprofit hospitals, Lee and Weisbrod (1977) developed a "collectiveness" index by which to compare the services of public, private, and nonprofit hospitals. Through their research, they found that the service mix of nonprofit hospitals is more like that of public hospitals than that of private hospitals, and "that voluntary hospitals differ from private

hospitals in the same way as do public hospitals," thus suggesting that nonprofit hospitals specialize in public goods as does the public sector (Lee and Weisbrod, 1977, p. 81).

Through the private provision of public goods, nonprofit organizations presumably make positive contributions to society by saving money that the government would otherwise have to spend and, perhaps, would spend less efficiently. Citing the research of James, James and Rose-Ackerman note that

...constraints on the government's ability to use market-clearing prices and wages make it cheaper to delegate production of quasi-public goods to the private sector and monitoring problems frequently make it politically expedient to choose nonprofit rather than for-profit organizations for this delegation and subsidy. (James and Rose-Ackerman, 1986, p. 20)

By delegating some economic production to the nonprofit sector, some researchers believe that nonprofit organizations may not only save money for the government, but also may be Pareto-superior to the government's providing public goods alone.

If government production does not go down as a result [of the private production of goods through nonprofits] and if private benefits do not exceed social benefits, the possibility of supplementary private production moves us closer to efficiency. (James and Rose Ackerman, 1986, p. 27)

Using economic models and game theory, however, Weiss (1986) demonstrates the conditions under which the private provision of public goods is not necessarily Pareto-superior. Specifically, he demonstrates that if the private provision of public goods does indeed reduce governmental expenditures on public services,

those with high demands for public services may end up worse off when nonprofits exist.

How do nonprofit hospitals fit into the picture of nonprofits as quasi-governmental agencies? While most nonprofit hospitals were originally founded to help a specific group of people -- whether a specific ethnic or religious group or the citizens of a particular locale -- it was not long before nonprofit organizations opened up their services to a more ethnically, socially, and economically diverse group of people. Through their expanded public service activities, nonprofit hospitals often took the lead in providing services that the government could not or chose not to provide its citizens. Thus, the development of a theory which suggests that nonprofit organizations arise in response to governmental failures reflects the nonprofit's expansion into many social welfare areas, and particularly in the area of health care.

The Nonprofit Form: A Response to Market Failure

A third theoretical argument, developed first by Hansmann (1980, 1987), and later by Easley and O'Hara (1986), and by Ben-Ner (1986), suggests that nonprofit organizations arise because of market failure. Generally, this theory suggests that nonprofits contribute positively to society by serving as corrections to problems of particular types of markets characteristically plagued by contract failure resulting from

problems of asymmetric information, transaction costs, or agency problems (Krashinsky, 1986).

Hansmann, among others, argues that nonprofit organizations remediate situations where consumers cannot ordinarily or easily observe or monitor organizational inputs or outputs.

Consequently, ordinary contractual mechanisms do not generally operate effectively because there is an incentive to shirk on quality or "to capture for personal gain any fees paid by prospective consumers (James and Rose-Ackerman, 1986, p. 21).

According to the argument, nonprofits promote economic efficiency through the non-distribution constraint. The nondistribution constraint prohibits the distribution of earnings to shareholders and thereby serves as a signal to consumers that the nonprofit is 'trustworthy' because neither the nonprofit nor the individual manager has an incentive to take advantage of the consumer. Presumably, because the organization cannot realize a pecuniary gain, the consumer has a good incentive to invest the nonprofit with his/her trust in situations where the quantity and/or quality of the organization's output is difficult to detect.

The nondistribution constraint allegedly reduces the incentive for the firm to downgrade quality and reassures the consumer that high quality will be maintained. The consumer, finding the nonprofit more 'trustworthy,' is willing to contract with it for goods whose quality can be monitored. NPOs have a comparative advantage in the provision of such goods, and enhance the overall efficiency of the marketplace by enabling them to be produced and consumed. (James and Rose-Ackerman, 1986, p. 21)

Under circumstances where outputs cannot be easily monitored, nonprofits would have a comparative advantage over for-profits, Thus, their existence presumably increases the efficiency of the market by making it possible to produce goods and services that would not otherwise be produced.

How are nonprofit hospitals characterized by contract failure? Because nonprofit hospitals rely more on selling their services than on financing their activities through donations, Hansmann does not believe that the nondistribution constraint plays much of a role in providing consumers of health care with the type of additional information that remediates contract failure. Rather, Hansmann's view is that the development of nonprofit hospitals may be more of an historical artifact of a time when nonprofit hospitals relied more on donations than on the sale of health care services.

PROPOSED RATIONALES FOR TAX-EXEMPTION: REFLECTIONS OF THE HISTORICAL AND THEORETICAL DEVELOPMENT OF NONPROFIT ORGANIZATIONS

As is true of the development of nonprofit organizations, there is no single theory or rationale that explains the existence of tax-exemptions for nonprofit organizations, much less for nonprofit hospitals. Rather, several explanations have been offered. The logic of some of these explanations is strikingly similar to one or another of the theories that have been developed to explain the rise of nonprofit organizations: that nonprofits supplement or replace governmental services

and/or enhance beneficial community values or goals (Simpson and Lee, 1987, p.5); that nonprofits have a comparative advantage over the government in providing goods and services; and that nonprofits help the private market function more efficiently. A fourth rationale for tax-exemption -- more tied to current accounting practices than to the behavior of nonprofit organizations -- can also be suggested: that nonprofits are tax-exempt because technically, they make no "profit" on which they can be taxed.

Nonprofits Supplement or Replace Governmental Services

Consonant with the theory that says nonprofit organizations develop in response to governmental failures, the first rationale suggests that tax-exemptions are awarded to nonprofit organizations as a "reward" for undertaking activities that the government either cannot or chooses not to fund. Implicit in this rationale is some sort of quid pro quo where the government chooses not to tax nonprofit organizations in return for the socially desirable activities that nonprofits undertake. Presumably, if nonprofit organizations had chosen not to engage in these activities, the government itself would have had to bear the costs of producing them directly. This rationale was mentioned both in the Filer Commission report on philanthropic organizations (1975) and more recently by Hopkins in his work on The Law of Tax Exempt Organizations (1987) (cited in Dale, 1988).

As with the theory that nonprofits arise due to governmental

failure, the "in lieu of government" rationale for tax-exemption has its weaknesses. For example, it is obvious that health care in this country is not only provided by nonprofit hospitals, but that it is also provided through for-profit and governmentally sponsored hospitals. Why, then, does the government not accord tax-exemptions to for-profit hospitals when they also produce health services that presumably the government would have to produce if they did not exist?

The rationale for granting tax-exemptions to nonprofits on the basis of their "quasi-governmental" activity is also flawed because, to date, the government has made no effort to determine whether an actual monetary quid pro quo exists between tax-exempt organizations and the government. Do tax-exempt organizations actually provide services equivalent to their monetary tax-exemption reward? The benefit/cost calculation that will answer this question has yet to be done. However, even if this question were answered, the problem of the inconsistent treatment which currently requires that for-profit hospitals and not nonprofits pay local, state, and federal taxes, will still not be resolved.

**Having a Comparative Advantage, Nonprofit Organizations
Contribute to Market Efficiency and Pluralism in Production**

Presenting the rationale that tax-exemptions should be allowed nonprofits because they create an economic incentive for nonprofits to engage in activities where they do a better job than either the public or private for-profit sector, Dale (1988)

recognizes that nonprofits have a comparative advantage over the government or private sectors in certain production areas. Operating in areas where they have a comparative advantage, nonprofit organizations promote overall efficiency and presumably contribute to overall social welfare.

Whether nonprofit organizations actually have a comparative advantage over the other sectors, and whether they actually do a better job than for-profits operating in the same area of activity, is open to debate. However, the fact that many social services in this country are provided by the private nonprofit sector rather than by the government does speak to what Dale (1988) and Belknap (cited in Dale, 1988) have identified as still another justification for tax-exemption -- that nonprofit organizations contribute to pluralism by promoting diversity and private activity, sometimes in lieu of public sector activity.

As with the other rationales for tax-exemption that have been discussed, however, the pluralism rationale also has a fundamental weakness. Simply, as Dale notes, "the argument for pluralism proves too much because for-profit firms could also claim it..." (Dale, 1988, p.5).

Nonprofits Remediate the Problems of Contract Failure

By operating in areas where there is contract failure, nonprofit organizations enhance the functioning of the market. By increasing overall market efficiency, all of society is better off.

Given this reasoning, tax-exemptions can be justified on the grounds that they promote the efficient functioning of the market. Moreover, the tax-exemption incentive for nonprofits may be justified because of the difficulties nonprofit organizations have in raising capital.

Because they have no shareholders, nonprofits are particularly constrained in their abilities to raise money for capital development (Hansmann, 1980, 1987). Thus, tax-exemptions may be justified as a "crude" way to subsidize capital formation in the nonprofit sector. (Hansmann, 1981).

However, while it may be true that nonprofits are hampered in their abilities to raise capital, it is nevertheless unclear why tax-exemptions rather than some other form of financing provides the best assistance to nonprofit organizations. Moreover, in the absence of overwhelmingly clear evidence that nonprofit organizations are economically efficient, it is conceivable that the resources channeled to nonprofit organizations through the tax-exemption contribute to inefficiencies rather than to efficiencies.

Nonprofits Cannot Be Taxed Because They Make No Profit

Perhaps more dependent upon current accounting procedures than upon the nature of nonprofit activities is the rationale that nonprofit organizations should not be taxed because they literally do not make a profit. Addressing this concern, Bittker and Rahdert (1976) argue that

exempt organizations engaged in public service activities share one common feature: if they were deprived of their exempt status and treated as taxable entities, computing their 'net income' would be a conceptually difficult, if not self-contradictory task. (Bittker and Rahdert, 1976, p. 307)

However, others, most notably Hansmann (1981), believe that Bittker and Rahdert have "overstated" the difficulties involved in computing net income. Generally, these researchers believe that it would be possible to calculate the net worth of a nonprofit organization in the cases of commercial nonprofit organizations, which typically rely on the sale of goods and services rather than on donations to finance their activities.

THE CURRENT POLICY OF FEDERAL CORPORATE INCOME TAX-EXEMPTION

Several rationales, most of which derive from theories of the rise of nonprofit organizations, and most with obvious weaknesses, have been suggested as justifications for the tax-exemption of nonprofit organizations. Despite their weaknesses, however, they provide some background for understanding the current IRS criteria for tax-exemption. These criteria include both organizational and operational tests.

According to Section 501.c.3 of the IRC, nonprofit organizations, including nonprofit hospitals, must first be organized and operated as a nonprofit corporation before it can be exempt under this federal corporate income tax law. Specifically, Section 501.c.3 exempts

[c]orporations, and any community chest, fund, or foundation operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and which does not participate in, or intervene in (including the publishing or distributing of statements) any political campaign on behalf of any candidate for public office. (IRC Section 501(c)(3), 99th Congress, 2nd Session, 1987, St. Paul, MN: West Publishing Company, p. 669)

This passage broadly characterizes what are known as the organizational test, that is, that "no substantial part of the net earnings issue to the benefit of any private stockholder or individual;" and the operational test, that is, that exempt organizations be "operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes...."

The Organizational Test

Through the organizational test, the IRS mandates a "non-distribution constraint" for nonprofit hospitals (Hansmann, 1980, 1987). Specifically, the non-distribution constraint prohibits nonprofits from distributing organizational earnings to its members. Nonprofits can pay for labor and salaries. They can even earn a profit -- and indeed must earn an excess of revenues over expenses if they are to survive. However, the non-

distribution constraint dictates that these profits must be used to finance the activities of the organization, which has been founded to serve a limited number of purposes within a state's laws of incorporation.

In contrast to for-profit organizations, there are no stockholders or shareholders in nonprofit organizations because nobody owns the nonprofit corporation. The nonprofit corporation "owns itself," and because there are no outside equity interests, the organization is usually governed by a self-perpetuating board of directors.

Because "the organizational test is one of the easiest to clear," and because articles of incorporation "are ordinarily amendable and since after amendment, the resolution of an organizational test question is only the first step in determining whether an organization is exempt" (Hopkins, and IRS Exempt Organization Handbook, IRS 7751, Section 338(2)), matters of "greater substance" center around the operational test.

The Operational Test

Through the operational test, the IRS suggests several criteria against which to evaluate requests for tax-exemption. For the most part, these criteria are implicit rather than explicitly stated within the Code. Because of the ambiguity, it has become the task of the courts to develop further the meaning of these criteria.

Some of the operational criteria are prescriptive in that they define what an organization must do to maintain its tax-exempt status. Other criteria are proscriptive and outline what an organization may not do if it hopes to be granted an exemption from taxes. A summary of these implicit operational criteria includes the following:

- 1) prescriptive: that the purposes of the group must be "exclusively" charitable;
- 2) proscriptive: that the organization cannot advocate the election of a particular candidate or intervene in his or her election campaign;
- 3) and proscriptive: that nonprofits cannot be engaged in activities that generate profit, but which are unrelated to the primary purpose or mission of the organization without being taxed.

Obviously, these criteria are broadly defined. What does the IRS mean by "exclusively charitable purposes," the key term that provides the basis for the exemption of nonprofit hospitals?

Defining the Concept of "Charitable Purpose"

While the IRC does not define the term "charitable,"

[t]here is a substantial body of case-law throughout the U.S. interpreting tax exemption provisions as they apply to nonprofit community hospitals. Although there are significant exceptions, it is fair to say that the majority of these cases appear to stand for the proposition that an institution which: (1) offers hospital services to the general public; (2) is organized as a nonprofit corporation, and (3) satisfies certain limitations on private benefit, lobbying, etc. is entitled to an exemption. (Simpson and Lee, 1987, citing 71 AM JUR 2d STATE AND LOCAL TAXATION, Section 385 (1973) and Evangelical Lutheran. (Neb, 1967) (Hospitals operated as nonprofit institutions are universally classed as charitable institutions.)

Moreover,

The term 'charitable' is frequently used in this broader context notwithstanding the fact that 'charitable' is only one of the eight descriptive words and phrases used in the Code to describe the various organizations of Code Section 501(c)(3). That is, the term 'charitable' is considered a generic term and, in its expansive sense, includes 'religion,' 'scientific,' 'educational' and like purposes. (See United States v. Proprietors of Social Law Library 102 F. 2nd 481; 1st Cir. 1939)

Nonprofit hospitals are typically exempt from taxes because they are charitable in the "expansive" sense of the term.

Teaching hospitals, on the other hand, may be exempt because of their educational purposes.

At least at the time of their establishment, the charitable purposes of nonprofit hospitals were fairly obvious: in general, they were first established to provide health care to those who could not access it, whether for reasons of cost, discrimination, or unavailability. Religious nonprofit hospitals were often established to alleviate the problem of lack of access due to prohibitive cost or discrimination. Community nonprofit hospitals were often established to bring health care services to areas where they were previously non-existent. Thus, at the time of their founding, nonprofit hospitals were clearly charitable in purpose, and they were exempt from taxes because they helped more people access health care than would ordinarily be able to access it by paying for health care in their homes, as was common among the wealthy.

Obviously, providing free or below cost care was part, although not all, of the early mission of nonprofit hospitals. However, the economic status of the individuals who benefit[ed] from the nonprofit hospital's activities was not necessarily a factor in determining whether a nonprofit hospital was meeting the organizational and operational test for tax-exemption. Citing revenue rulings and case law, Hopkins (1979, p. 46) notes that the economic status of individuals is only a factor "where relief of poverty is the basis for the designation of the purpose as 'charitable.'"

Thus, the first operational criterion stated in the IRC, although ambiguously defined, is that a nonprofit hospital must have a charitable purpose. This charitable purpose, while not necessarily linked to the economic status of the potential recipients, has traditionally had a dimension of making health care available to those who could not otherwise access it. In some cases, lack of access was due to cost. In these cases, the obviously charitable purpose would be easily recognized by the hospital's providing free or reduced cost care. In other cases, lack of access was due to geographic unavailability, inconvenience, or market forces which made some types of health care or health care technology too costly to develop. In these cases, a hospital's charitable purpose was evident in providing services that were not cost-effective and/or in starting hospitals in areas that had previously been under-served. Thus, the first criterion for tax-exemption of nonprofit hospitals would seem to

be that they be engaged in a charitable purposes, and that the charitable purpose be, in some way, linked to the provision of health care to those who could not access it.

In 1956, the IRS recognized a hospital's charitable purpose in "the extent of its financial ability for those not able to pay for services rendered" (Rev. Rul. 56-185, 1956-1 C.B. 202). However, the 1956 ruling indicated that a nonprofit hospital may also accomplish its charitable purpose "by furnishing services at reduced rates which are below cost, or it may set aside earnings for use for improvements and additions to hospital facilities" (Clark, 1989).

By 1969, the IRS had modified its 1956 ruling and eliminated the requirement that a nonprofit hospital had to care for patients at no or reduced cost (Rev. Rul. 69-445, 1969-2, C.B. 117). Further, the hospital could limit admissions to those who demonstrated the ability to pay. It did, however, require, that if a nonprofit hospital operated a full-time emergency room, no one could be denied emergency treatment because of the inability to pay. This decision was later modified somewhat in 1983 (Rev. Rul. 83-157, 1983-2, C.B. 94).

Based on the 1969 ruling, charitable activity for a nonprofit hospital was evident simply because the hospital promoted health, which was of benefit to the community as a whole, even if the beneficiaries of hospital activity were not necessarily the indigent (Clark, 1989).

The "community benefit" dimension of this ruling reflects the second operational criteria for granting tax-exemptions to nonprofit hospitals. While not necessarily distinct in all ways from the first criterion, the second criterion links charitable purpose to a social or community welfare dimension. Drawing from the law of charitable trusts and English Common Law, Hopkins researched the concept of charity and found that it included the following:

1) the relief of poverty by assisting the poor, distressed and underprivileged, 2) advancement of religion, 3) advancement of education and science, 4) performance of government functions and lessening of the burdens of government, 5) promotion of health and 6) promotion of social welfare for the benefit of the community
(Hopkins, 1979, p. 44)

Thus, it is English Common Law, later reinforced by judicial rulings, that establishes the second criterion for the operational test for tax-exempt organizations: that is, that tax-exempt organizations must promote the social welfare for the benefit of the community. According to Hopkins, "the result of the organizations' activities and the assistance [may be] considered 'charitable' in nature as long as the effect is to benefit the community rather than merely individual recipients" (Hopkins, 1979, p. 47). Citing Res. Trusts 2d Section 368 (comment a.) and an 1877 Supreme Court ruling (95 U.S. 303, 311 (1877)), Hopkins concludes:

...the 'common element of all charitable purposes is that they are designed to accomplish objectives which are beneficial to the community.' A frequently cited case on this point is Ould v. Washington Hospital for Foundlings, where the Supreme Court stated: 'A charitable use, where neither law nor public policy forbids, may be applied to almost anything that tends to promote the well-doing and well-being of social man. (Hopkins, 1979, p. 51)

Not unlike the definition of charitable, neither the IRS nor the courts say much about the nature or amount of the beneficial activities, nor about the operating style of the organization. Nor do they state anywhere that charitable care is to be defined as free care or free service, although providing free service to people, especially, the poor, is certainly one kind of charitable or socially beneficial activity. Quite the contrary, the Supreme Court has held that nonprofit hospitals do not have to provide any free care at all in order to be charitable.

Just as the law does not require nonprofit organizations to provide services free of charge, neither does it require that nonprofit organizations refrain from engaging in activities undertaken in the private for-profit or public sectors. Nor does the law require that nonprofits improve upon what the for-profit and public sectors do. While some of these ideas may be suggested in the rationales that have been developed for tax-exempt organizations -- rationales that derive from and reflect the historical and theoretical development of nonprofit organizations -- current tax law requires nonprofit organizations to meet the organizational and operational tests for tax-exemption:

organizationally, that nonprofit organizations be subject to the nondistribution constraint; and operationally, that nonprofits be engaged in a charitable purpose and that they serve the community by engaging in activities that benefit the social welfare in some way.

A REVIEW OF EMPIRICAL RESEARCH ON NONPROFITS

When health care organizations are threatened with extinction, any treatment that accords a financial advantage to one type of organization over another is often viewed as a competitive advantage by the rival organizations (Seay, 1988). While unfair competition is not necessarily in evidence due to differential tax treatment (Rose-Ackerman, 1986c), the current policy of tax-exemption is frequently perceived as the government's giving an important financial advantage to nonprofit hospitals when, according to some critics, research has shown that there are few or relatively insignificant differences between for-profit and nonprofit hospitals. What, specifically, has empirical research shown about the differences between for-profit and nonprofit hospitals?

Supporting the findings of differences between nonprofits and for-profits, Ruchlin, et al., (1973) found that nonprofits provided more therapeutic and occupational therapy per inpatient day than for-profits. More germane to the tax-exemption question, however, they also found that despite the reporting of similar demographic and income characteristics, for-profit

investor-owned chain hospitals reported "a lower proportion of their patient census with public third-party payer coverage than their nonprofit counterparts" (p. 21). That is, Ruchlin, et al., found evidence of "skimming" in for-profit hospitals. In a subsequent re-evaluation, Rafferty and Schweitzer (1974) found that proprietary "skimming" was probably understated in the prior work of Ruchlin, et al.

Also concerned with the "skimming" problem, Sloan and Vraciu (1983) reached a different conclusion than Ruchlin, et al., and Rafferty and Schweitzer. Using data from Florida, they found few differences between for-profits and nonprofits in terms of the percentages of Medicare and Medicaid patient days. In addition, by using a net operating revenue cost measure per adjusted admission, they found that nonprofit and for-profit hospitals were virtually identical in net operating funds, in after-tax profit margins, and in the amount of uncompensated care adjustments to operating revenue. Further, Sloan and Vraciu found that nonprofit hospitals were no more likely to offer "nonprofitable" services than for-profit hospitals.

Most recently, Herzlinger and Krasker (1987) have also addressed the skimming question and whether the poor/uninsured/medically indigent have better or worse access to for-profit or nonprofit hospitals in terms of the range of services being offered. Their research indicated that there was no difference between nonprofit and for-profit hospitals in the range of services being offered to the medically indigent.

Similar findings of no difference in levels of uncompensated care were reported by Richards (1984) and the AHA (1986), both of whom were cited in Lewin, et al. (1988), and for systems, Shortell, et al., (1986).

Reporting different results, however, a survey conducted by the Office of Civil Rights (OCR) in 1981 reported that while public hospitals bear the greatest proportion of uninsured patients -- 16.8 percent -- nonprofit hospitals admitted 7.9% uninsured while for-profit hospitals admitted 6% (OCR, cited in Institute of Medicine (IOM), 1986b). Moreover, data from a 1983 AHA survey reported that uncompensated care constituted 4.2% of gross patient revenues in nonprofit hospitals, and 3.1% in for-profit hospitals (AHA, cited in IOM, 1986b).

Turning from the issue of skimming to a comparison of costs, Sloan and Vraciu found that for-profit hospitals had lower operating expenses than nonprofit hospitals. A 1986 report of the IOM, however, contradicts their findings about costs and expenses at for-profit hospitals (IOM, 1986a). Recognizing that variations in the cost allocation processes "can make expense comparisons among institutions imprecise" (IOM, 1986a, p. 75), the IOM reviewed the literature contrasting expenses in for-profit and nonprofit hospitals. They found that in six of the seven studies that compared expenses per admission, for-profit expenses were higher. These differences ranged from statistically insignificant levels to 8% to 10% higher (Pattison and Katz, 1983; Becker and Sloan, 1985; Pattison, 1986; Coelen, 1986).

Moreover, when charges were measured per inpatient day or admission, or in Medicare charges per case, the IOM found that for-profit hospitals were generally higher than nonprofit hospitals. Further, additional research indicated that for-profit hospitals, which had significantly lower occupancy rates than nonprofit hospitals (Kralovec, 1985, cited in IOM, 1986), had not contained rising expenses during the late 1970s and early 1980s any better than did nonprofit hospitals (Coelen, 1986; Pattison, 1986).

In terms of administrative costs, national and California data showed that for-profits have higher costs than nonprofit hospitals (Pattison and Katz, 1983; Pattison, 1986; Watt, et al., 1986a). In addition, Watt (1986a) showed that for-profit hospitals employed fewer full-time equivalents per average adjusted daily admission, but also paid higher salaries and benefits per employee than did nonprofit hospitals.

Focusing on capital costs, Anderson and Ginsberg (1983) and Watt, et al. (1986a,b) found that for-profit chains operated with "significantly higher capital costs relative to operating costs" than did nonprofit hospitals (IOM, 1986a, p.80). Other researchers, who focused on comparing the profitability of nonprofit and for-profit hospitals, found that, depending on the measures, for-profits had achieved more profitability before and after taxes than nonprofits (Lewin, et al., 1981; Watt, 1986a,b, Coelen, 1986). Using 1980 Florida data, however, Sloan and Vraciu (1983) found the opposite to be true. Using statistical

controls, Sloan and Vraciu found no statistically significant difference in after-tax margins of for-profits and nonprofit chains.

In terms of the relative efficiency of nonprofit hospitals versus for-profit hospitals, Freund, et al., (1985) found that for-profit hospitals were not more efficient than nonprofit hospitals when efficiency was measured in terms of length of stay. This empirical finding stands in contradiction to the earlier theoretical work of Clark (1980), who maintains that nonprofit hospitals are fundamentally inefficient and that they exploit their patrons, and James and Rose-Ackerman (1986), who argue that nonprofits are characterized by managerial inefficiencies, if not improprieties, because nonprofits do not have a monitoring body that is able to oversee the outputs of the organization.

In one of the earliest studies of nonprofit hospitals, Newhouse (1970) concluded that nonprofit hospitals were inefficient. While ignoring case load and service-mix differences between teaching and non-teaching hospitals, Newhouse found that nonprofit hospitals do more esoteric procedures than routine ones.

In a later study of system-related hospitals, Shortell, et al., (1986) found that nonprofit system hospitals provide more alternative services than for-profit system hospitals in all service subcategories except for outpatient diagnostic services. Further, Friedman and Shortell (1988) found that nonprofits and

for-profits were comparable in terms of quality of services and in costs per adjusted admission, after allowing for diversification and growth strategies.

While most comparisons of for-profit and nonprofit health care organizations have been undertaken on hospitals, acute care facilities are not the only type of health facility where researchers debate differences. For example, Hall and McGuire (1987) contrasted for-profit and nonprofit mental health clinics. They found that "payments to proprietary mental health clinics exceeded payments to private nonprofit clinics by 27%, public clinics by 19%, and religious clinics by 17%." This finding suggests that for-profit clinics are more commercially orientated than nonprofit facilities (p. 1179).

Obviously, empirical research on the similarities and differences between nonprofit and for-profit hospitals and health care facilities has not resulted in clear-cut statements about the efficiency or contributions of nonprofits relative to for-profits. While the literature establishes some differences between nonprofits and for-profits, especially in terms of service-mix, charges, costs, or length of stay, the statistical and substantive importance of these differences varies widely depending on the nature of the sample, the methodology, and/or the data that were analyzed.

Despite the inconclusiveness of this research and the fact that most of these studies were undertaken for organizational rather than policy purposes, the results of some of these studies

are being used in arguments for or against the differential treatment the government accords nonprofit hospitals relative to for-profit hospitals. The underlying principle in this approach is implicit, but clear. By at least one definition, justice occurs when entities of "one and the same essential category" are treated the same way (Perelman, 1980, p. 11). Hence, for differences in treatment of for-profit and nonprofit hospitals to be just, nonprofit and for-profit hospitals must belong to essentially different categories. If this is not the case, then the preferential treatment accorded nonprofit hospitals is clearly unjustified.

But what constitute the essential differences between nonprofit and for-profit hospitals? This question, clearly one that is not easily answered by researchers, raises additional questions for those in the academic, policy-making, and health care communities alike.

- * Do nonprofit and for-profit hospitals provide ostensibly the same services, or are there essential differences between the two?
- * How are these differences reflected in the mission and operations of nonprofit hospitals?
- * What should a nonprofit hospital be doing to merit its tax-exempt status?
- * How are health care providers responding to challenges on their tax-exempt status? How should they be responding?

While relatively ambiguous and untested at the federal level, and varied at the state level, the criteria for tax-exemption for nonprofit hospitals mandate that a hospital be

engaged in a charitable purpose and that its activities benefit the community.

- * Operationally, what types of activities constitute charitable and community benefit activities? How can they be measured? Who determines how much charity care and community benefit activity is "enough" to merit tax-exempt status?
- * By whose standards, and to what degree must a nonprofit hospital demonstrate that it is meeting the operational tests of doing charitable activities and/or activities that are beneficial to the community?
- * Given that it is possible to identify, operationalize, and measure how nonprofit hospitals differ essentially from for-profit hospitals, does demonstrating a difference warrant a tax-exemption for nonprofits?
- * In terms of equity and efficiency, is a policy of tax-exemption, whether from the corporate income tax or from the property tax, the best way to promote health care in the nonprofit sector? the best way provide health care for the indigent? or the best way to contain the escalating costs of medical care? or are there more effective policies that can be adopted?

While gains in efficiency may be realized by a nonprofit's becoming more businesslike, many question whether survival has totally supplanted other organizational goals, especially those related to a nonprofit hospital's traditional mission of stewardship, trust, and public service, especially to those without access to health care.

- * Is it true that nonprofit hospitals have abandoned their service mission for bottom-line considerations?
- * Should nonprofit hospitals continue to be "rewarded" for the services they provide, presumably in lieu of the government's providing them?

- * And more specifically, is an exemption from taxes, whether corporate or property, the best reward for their contribution?

Presumably, tomorrow's speakers at the Bugbee Symposium will provide more information that will make possible an intelligent discussion of these issues.

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